DPHHS-SLTC-108
(Rev. 2/02)

STATE OF MONTANA
Department of Public Health and Human Services
Senior and Long Term Care Division

SUPPLEMENTAL SECURITY INCOME
CERTIFICATION/CHANGE OF STATE SUPPLEMENTAL PAYMENT

TO BE COMPLETED ON BEHALF OF CURRENT SSI RECIPIENT OR POTENTIAL ELIGIBLE

SENT TO: **Social Security District Office** _____
(City)

(Name of Individual) **(Social Security Number)** **(Date of Birth)**

(Name of Facility) **(Street Address)**

(Mailing Address)

TYPE OF ACTION:

☐ **New Applicant** ☐ **Address Change** ☐ **Payee Change** ☐ **Change of Payment Rate**

☐ **Other (explain):** _____

TYPE OF INDIVIDUAL: **Developmental Disability _____** **Mental Disability _____** **Physical Disability _____** **Aged Only _____**

1. Above individual:

☐ **is a current OASDI recipient** ☐ **is a current SSI recipient** ☐ **is not an SSI recipient** ☐ **has applied for OASDI or SSI (circle which one)**

2a. Above individual is residing in:

☐ **Approved Developmentally Disabled Transitional Living Services (Code K)**
☐ **Licensed Group Home for the Severely Disabled (Code I)**
☐ **Licensed Child Foster Home or Group Home (Code J)**
☐ **Licensed Group Home for the Mentally Disabled (Code H)**
☐ **Licensed Adult Foster Home (Code J)**
☐ **Licensed Personal Care Facility (Code G)**
☐ **Licensed Group Home for the Developmentally Disabled (Code I)**

2b. DPHHS license number of facility: _____

2c. Date residence in above licensed/approved facility began: (month/day/year) _____

3. For a disabled child, indicate date of SSI application: (month/day/year) _____

4. State Supplemental Payment is effective: (month/day/year) _____

5. I recommend: ☐ **Individual as his/her own payee** ☐ **Representative payee for individual**
Name & address: _____
_____
_____

6. Because the above individual is not present and the time necessary to contact him/her may result in a loss of benefit, I understand this form will protect the rights to any SSI payments which may be due him/her from the Social Security Administration.

7. CERTIFICATION

Case approved for State Supplemental Payment level: (SSA Code) _____ **County** _____

_____
(Printed name of DPHHS Employee/Representative) **(Title)** **(Phone Number)**

_____
(Agency Name) **(Address)** **(City, State, Zip Code)**

_____
(Signature of DPHHS Employee/Representative) **(Date)**

NOTE: **Send yellow copy to: SSP Program, Senior & Long Term Care Division, P.O. Box 4210, Helena, MT 59604-4210.**

Distribution: White-Social Security District Office; Yellow-SLTC; Pink-Originator